DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at this facility from April 10, 2018 through April 17, 2018. The facility census on the first day was 151. The survey sample included 8 residents. Abbreviations/definitions used in this report are as follows: NHA- Nursing Home Administrator; DON- Director of Nursing; DOR - Director of Rehabilitation; ADON-Assistant Director of Nursing; MD - Medical Doctor; RD - Registered Dietician; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; WNRN - Wound Nurse RN; CWCNP - Consultant Wound Care Nurse Practitioner; CNA - Certified Nurse's Aide; Alzheimer's dementia - A type of dementia which includes impaired thinking and memory; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment Bilateral-both sides; Blanchable-skin looses redness with pressure; Braden scale - test used to determine risk for developing pressure ulcers; CAA - Care Area Assessment section of the MDS that triggers areas to a resident's problems, needs, or strengths;	F 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2018

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F 000	Continued From page 1 Central venous access devices (CVAD) - small, flexible tubes placed in large veins for people who require frequent access to the bloodstream; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Cognitive-process of knowing and understanding; Contact Isolation - precautions used for infectious diseases that are spread by touching the contaminated area; Electronic Medical Records (EMR) - electronic documentation system of medical records; ER - Emergency Room; Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Hematoma - a localized collection of blood outside the blood vessels; House barrier lotion - help protect the skin from excess contact with moisture and especially useful for those who wear protective underwear where feces or urine will come in contact with the skin for a length of time; Heel protector - device which lift the heel off of the mattress, minimizing pressure on the heel; Hydrocolloid -a substance which forms a gel in the presence of water; Hydrogel - a gel in which the liquid component is water; Hydrogen peroxide - a liquid chemical used for killing bacteria; Hoyer lift- mechanical lift used to transfer resident from one surface to another;	F 000		

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F 000	Continued From page 2 Ischium - the curved bone forming the base of each half of the pelvis, bony areas on the bottom of each buttock; Incontinence/incontinent - lack of bowel and/or bladder control; Indwelling suprapubic urinary catheter - a tube that carries urine from the bladder to the outside of the body; IV - intravenous/into a vein; Low air loss mattress - used for prevention and treatment of pressure ulcers to evenly distribute a resident's body weight over connected pillows of air with a blower, minimizing pressure over bony prominences (the areas that are most vulnerable to pressure ulcers). MAR - Medication Administration Record; Medihoney - treatment for a PU; MDS - Minimum Data Set (standardized assessment forms) used in nursing homes; Multiple Sclerosis - degenerative process of the central nervous system; Neurological assessment - An assessment to check the status of the body's nervous system including level of responsiveness and movements; NS/NSS - Normal Saline/Normal Saline Solution - a 0.9% sterile solution of sodium chloride in water; P & P - policy and procedure; Physician Order Sheet (POS) - monthly report of active physician orders; Parenteral - an IV (intravenous - into a vein) infusion of various solutions to maintain adequate hydration, restore and/or maintain fluid volume, reestablish lost electrolytes (minerals in the body) or provide partial nutrition; PICC - Peripherally Inserted Central Catheter/a thin, soft, long tube that is inserted into a vein in the arm, leg or neck and used for long-term	F 000		

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F 000	Continued From page 3 intravenous (IV) antibiotics, nutrition or medications; Prosource - protein supplement Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; PU Stages: - Stage I (1) - Intact skin with a localized area of non-blanchable erythema, in which the redness on the skin, when pressed does not go away; . - Stage II (2) - blister or shallow open sore with red/pink color; - Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin; - Stage IV (4) - Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen; - Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar or necrotic (hard dead tissue that is tan, brown or black). Eschar or necrotic is worse than slough; -Deep Tissue Injury (DTI) purple or maroon intact skin or blood filled blister; -Suspected Deep Tissue Injury (SDTI); PU characteristics: - Undermining - skin edges have lost contact with underlying tissue; - Tunneling - A wound having a small entrance and exit of uniform diameter; - Peri-wound - bottom of a wound; - Granulation tissue - new tissue and small blood vessels that form on the surfaces of a wound during the healing process; PRN - as needed; Sacral-large triangular bone at the base of the spine;	F 000		

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F 000	Continued From page 4 Shear force-friction exerted when resident moves in bed; Skin prep no sting - a liquid film-forming dressing that, upon application to intact skin, forms a protective film; STAT - with no delay; at once; Severe Cognitive Impairment - unable to make own decisions; Superior vena cava- blood vessel that carries blood from the upper part of the body into the heart; Total assistance - Resident unable to perform the activity and required total assistance of staff to perform the activity; T & R - Turn and Repositioning or Reposition; Thickened fluids- fluid that has had the consistency increased to aid a resident with swallowing difficulty; Urethra - the duct by which urine is conveyed out of the body from the bladder; Urinary tract infection (UTI) - when bacteria gets into your urine and travels up to your bladder and causes an infection; WEF - (Wound Evaluation Form) - assessment of the wound; @ - at; BID or bid - twice a day; cm (Centimeter) - a measurement of length; e.g. (exempli gratia) - means "for example"; etc-and so forth; i.e. - that is; L - length; W - width; D - depth; # - (lb) pound; < - less than; % - percentage; x - times or by; ml - milliliter; a liquid measure.	F 000		

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have a system which identified the need to complete a significant change in condition MDS assessment for one (R3) out of eight sampled residents. R3 experienced a significant change in condition when she acquired a new stage 3 pressure ulcer (PU) and had a significant weight loss. Findings include: According to the CMS Long-Term care Facility RAI (Resident Assessment Instrument) User's Manual (Version 3.0 - October 2014), a significant change in status assessment must be performed if a resident experiences a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS). R3 met these two requirements: 1. Emergence of unplanned weight loss (5%	F 637	A. R3 had a significant change MDS completed on 4/17/18. B. An MDS audit will be conducted on all MDS's within the last 30 days to determine if any significant changes are required. Any MDS identified requiring a significant change will be completed at that time. C. The MDS Coordinators will be educated by the corporate MDS consultant regarding identification of areas of significant change based on the RAI manual. Discussion will occur in morning meeting with the IDT regarding resident changes in the areas of ADL's, wounds, weight, cognition and continence that would indicate declines or improvements and trigger a significant change. Reports generated from Care	6/14/18

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F 637	Continued From page 6 change in 30 days or 10% change in 180 days). 2. Emergence of a new PU stage 2 or higher or worsening in PU status. Review of R3's clinical records revealed: 1/11/18 - The quarterly MDS assessment indicated that R3 had no PU. 1/21/18 - The discharge MDS assessment documented that R3 had no PU. 1/29/18 - R3 was readmitted to the facility after being hospitalized. 1/29/18 2:36 PM - Admission Nursing Note documented: Skin check completed on admission. Skin warm dry intact. No skin breakdown noted. 2/7/18 6:34 AM - Registered Dietician (RD) Note documented: Currently weekly weights of 139.7# to 143.6 # which suggested a significant weight loss of 15.2# or 9.8% since readmission on 1/29/18. 2/19/18 12:24 PM - RD Note documented: R3 with new stage 3 PU of the ischium. Will recommend to start Prosource twice a day to aid in wound healing. Will monitor intakes, weights, labs, trends for need to adjust nutritional interventions. 2/27/18 5:45 AM - RD Note documented: weight of 144.4#, a significant weight loss of 9# or 5.9% in 30 days. 2/29/18 1:28 PM - Progress Note by E6 (WNRN) documented: a new stage 3 PU.	F 637	Tracker and PCC will also be utilized to aide in identifying significant changes. D. An audit tool will be created that will analyze each MDS within the last 30 days to ensure that any significant change is captured. Audits will be completed weekly x 1 month and monthly x 2 months and until 100% compliance is achieved. Audits will be completed by the MDS Coordinators or designee. Results will be pulled through the QA monthly meeting for review x 3 months.	

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F 637	Continued From page 7 4/5/18 8:46 AM - RD Note documented: weight of 137.4#, a significant weight loss of 16# or 10% in 90 days. The facility failed to complete a significant change MDS assessment for R3. 4/17/18 10:00 AM - During an interview, E9 (RNAC) stated that she definitely would do a significant change MDS assessment with a stage 3 pressure ulcer and a significant weight loss because it met requirements of a significant change assessment in the MDS. E9 stated that R3 was not assigned to her and referred interview to E10 (MDS/Assistant). E10 stated that a significant change MDS assessment should have been done. E10 reported that she knew about the pressure ulcer, but was not made aware of the significant weight loss and did not identify the weight loss documented in the RD's note. E10 stated "I don't remember it being said in morning meeting. That is where we would have heard about it. I would have done one if I knew of both changes." The facility failed to complete a significant change in status within 14 days from knowledge of the two significant declines. A significant change comprehensive assessment requires that CAA's (Care Area Assessment) and comprehensive care plan review be completed, which drives the new plan of care with these changes. 4/17/18 at approximately 4:30 PM, findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E4 (LPN) during the Exit Conference.	F 637		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/14/18

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F 686 SS=G	Continued From page 8 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide the necessary treatment and services, to promote healing of a pressure ulcer (PU) for two (R3 and R4) out of eight (8) sampled residents. R3, a dependent resident, developed an avoidable PU to the left ischium and the facility failed to accurately assess the risk for developing a PU and failed to provide individualized interventions for pressure reduction resulting in worsening of the PU. The facility failed to ensure R4's left heel PU was accurately staged and that physical characteristics of the PU were thoroughly and completely documented. Findings include: National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, 2nd edition 2014, Assessment of Pressure Ulcers and Monitoring of Healing, stated:	F 686	A. R3 had all appropriate interventions in place prior to survey exit. A new Braden Assessment was completed. No further interventions were implemented. R4 was discharged from the facility on 4/23/18. B. A facility wide skin integrity audit will be completed through observation and Braden review to ensure that appropriate interventions are in place and care planned accordingly. Any resident identified as requiring new interventions will be implemented immediately. C. Nursing staff will be re-educated on the Braden scale assessment by the Staff Development nurse or designee. The Pressure Ulcer Policy and Procedure will be revised to reflect the 2016 NPUAP guidelines with a corresponding	

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F 686	Continued From page 9 1. Assess and document physical characteristics including: -Location -Stage/Category -Size -Tissue type -Color -Periwound condition -Wound edges -Sinus tracts -Undermining -Tunneling -Exudate -Odor 2. Mattress and bed support surfaces guidelines for individuals with existing PU include: -Whenever possible, do not position an individual on an existing pressure ulcer. -Select a support surface that provides enhanced pressure redistribution, shear reduction and microclimate control for individuals with stage 3, 4 and unstageable pressure ulcers. The facility's policy and procedure titled Skin and Wound Management (undated) provided by E2 (DON) stated: - Upon discovery of a resident with impaired skin, the licensed nurse will notify the Wound Nurse RN or designee. The Wound Nurse RN or designee will assess the wound and determine if it is a PU and then initiate the appropriate treatment. - The licensed nurse or Wound Nurse RN or designee will notify the attending physician and resident (if capable of understanding) or resident's representative. Documentation will be completed in the resident's medical record to	F 686	intervention in place for each score from mild to severe. Additionally, the EMAR Admission/Readmission Screener will be revised to eliminate "suspected" from deep tissue injury and characteristics will be added. D. All new admissions and readmissions will be assessed by the wound care nurse or designee to include a skin assessment, Braden assessment review and appropriate interventions placed and care planned. An audit will be completed by the WCN or designee to ensure the accuracy of the findings weekly X4 then monthly X2 and until 100% compliance is achieved. Audit results will be pulled through the QA Committee monthly X 3.	

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F 686	Continued From page 10	F 686		

include notifications, and orders/changes to treatment will be documented and the care plan will be updated.

The facility's policy and procedure titled Prevention of Pressure Ulcers/Injuries provided by E2 (DON) and last revised July 2017 stated:
-At least every two hours, reposition residents who are reclining and dependent on staff for repositioning.
-Reposition more frequently as needed based on the condition of the skin and the resident's comfort.

The facility's policy and procedure titled Support Surface Guidelines provided by E2 (DON) and last revised September 2013 stated:
-Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air or air-loss when lying in bed.
-Use a pressure ulcer risk scale, such as the Braden Scale, to help determine need for and appropriate type of pressure-relieving devices. Residents scoring above 9 may be further assessed to determine the most appropriate device.

1. Cross refer to F637

Review of R3's clinical record revealed:

7/12/17 - R3 was originally admitted to facility.

7/13/17 - Care planned initiated for at risk for alteration in skin integrity. Interventions included: barrier cream to periarea/buttocks every shift and as needed; check for incontinence and provide incontinent care as needed; utilize draw sheet to

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F 686	Continued From page 11 aid in bed mobility; and (intervention added on 11/13/17) turn and reposition and check skin every 2 hours. 12/21/17 - Care plan initiated for resistive/noncompliant with thickened fluids related to: disbelief in value of treatment, refuses incontinence care, demands to be in wheelchair for extended periods of time, noncompliant with limiting time out of bed with a goal that resident will verbalize understanding of consequences of refusal/noncompliance, but there were no interventions to educate R3 on the consequences of refusal/noncompliance or to explore with R3 the reasons for noncompliance. 1/11/18 Quarterly MDS documented R3: -required extensive assistance with more than two persons assist with bed mobility, transfer, dressing, toileting and personal hygiene; -was totally dependent for bathing; -was cognitively intact; -was always incontinent of urine and bowel; -was at risk for PU; -had treatments for pressure reducing device for chair, turning and positioning, application of ointments/medications. 1/29/18 - R3 was readmitted to the facility after being hospitalized. 1/29/18 2:36 PM - Admission Nursing Note documented: Skin check completed on admission. Skin warm dry intact. No skin breakdown noted. 1/29/18 Readmission Braden Scale was 16 (15-18 indicates mild risk for developing a PU). However, a more appropriate score would be 14	F 686		

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F 686	Continued From page 12	F 686		

(moderate risk) based on decreasing the scores for nutrition and friction/shear. For nutrition, the facility scored R3 as excellent (4 points), but adequate (3 points) was more appropriate (Eats over half of most meals. Eats total of 4 servings of protein each day. Occasionally refuses a meal, but will usually take a supplement). For friction/shear the facility scored R3 as a potential problem (2 points). Because, R3 required moderate to maximum assistance in moving, a problem (1 point) would be a more appropriate score. The lower the Braden score, the more likely the facility staff would be alerted to the potential that a resident may develop a PU, and therefore the more likely they would implement preventative measures.

2/2/18-2/18/18 Review of the Detailed CNA Documentation of turning and repositioning (before the stage 3 PU was identified), revealed:
-R3 refused turning and repositioning only 7 out of 127 opportunities to be turned (8.9%).
-R3 was not turn and reposition by staff 19 out of 127 opportunities to be turned (24%).

Prior to the identification of a stage 3 PU on 2/18/18, facility failed to ensure R3 was turned and repositioned based on the plan of care. The facility failed to show evidence that R3 was educated on risk of prolonged periods of time in wheel chair or in bed without pressure relief.

2/5/18 10:35 PM - Weekly Skin Evaluation: Resident has no new open area.

2/5/18 - Weekly Braden Scale was 16. However, a more appropriate score would be 14 (moderate risk) based on decreasing the nutrition and friction/shear scores (as discussed above).

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	085020	A. BUILDING _____ B. WING _____	C 04/17/2018

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F 686	Continued From page 13 2/6/18 Occupational Therapy Note documented: R3 is a quadriplegic with no movement of legs, weak trunk and arms; dependent hoyer lift transfers. When determining R3's risk for developing a pressure ulcer, the facility relied on inaccurate Braden scores rather than other documented assessment findings of incontinence, sensory deficits and paralysis of lower extremities. 2/12/18 6:09 AM - Nursing Note documented: An area of firm, blanchable redness noted to the ischium area this shift, no open area at this time. CNA was instructed to monitor for wetness frequently secondary to incontinence, explained the need for barrier cream and reposition every 2 hours (or more frequently if able). Pressure was relieved to area. Resident denies any pain or discomfort to the area at this time. 2/12/18 3:59 PM - Nursing Note documented: Resident was assessed by wound nurse today. Resident was previously noted to have a hard area to the right ischium. On assessment resident noted to have scar tissue to the right ischium from a previous healed wound. Resident was noted to have peeling skin to the bilateral groins/bilateral buttocks areas. 2/12/18 Weekly Braden Scale was 15. However, a more appropriate score would be 12 (high risk) based on decreasing sensory perception, mobility and friction/shear scores. The extent of R3's lower body mobility and sensory perception was limited by Multiple Sclerosis disease progression and not accurately included in scoring the Braden scale.	F 686		

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F 686	Continued From page 14 2/12/18 10:53 PM - Weekly Skin Evaluation: Resident has previous reddened peeling skin to groin areas; barrier cream being applied. 2/13/18 9:37 PM- Nursing Note documented: Left ischium redness noted with scant amount of blood. Area cleansed, dried and covered with skin protectant as ordered. Redness also noted to sacral area and again covered with skin protectant. Right upper thigh and peri-area-excoriated. Cleansed and dried. Skin protectant applied. On- coming shift notified. There was no evidence that an assessment of this wound was conducted to determine if this was a PU. 2/15/18 9:35 PM - Nursing Note documented: Resident received a shower this shift. Out of bed for dinner. Retired to bed at 9:00 PM. Resident complained that her aide took long to toilet her. Nurse explained to her that her aide was in the middle of giving care and would attend to her as soon as she was done. 2/18/18 2:48 PM - Nursing Note documented: New treatment in place as per Wound Care. Left Ischium cleansed with saline. Dried. Medihoney applied and covered with clean dry dressing. Resident is in bed at this time with weight offloaded from this area. Every 2 hour turn initiated while in bed. There was lack of evidence that the facility completed a comprehensive wound assessment (including tissue type, color, periwound condition, wound edges, sinus tract, undermining, tunneling, exudate, and odor) and reassessed the current	F 686		

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F 686	Continued From page 15 interventions to relieve pressure in the affected area. Although E24 (LPN) off-loaded the left ischium, there is no evidence that this intervention was added to the care plan or communicated to other staff. The facility failed to show evidence that R3 was educated on risk of prolonged periods of time in the wheel chair without pressure relief. 2/19/18 Weekly Braden Scale was 13 (moderate risk). However, a more appropriate score would be 12 (high risk) based on decreasing sensory perception and friction/shear score as discussed above. 2/19/18 Advanced Healing Wound Evaluation Form by E13 (Consultant Wound Care Nurse Practitioner) documented: -left ischium stage 3 PU; -measurements 2.5 cm x 3.0 cm x 0.2 cm; -moderate serous drainage; -wound color red, yellow purple; -slough 10%; -treatment: cleanse with NSS, apply Medihoney and foam dressing every other day & prn. 2/19/18 Physician order - Cleanse left ischial wound with sterile saline. Pat dry. Apply Medihoney to wound bed and cover with a new dry dressing every day shift for wound care. 2/19/18 - Care plan initiated for a left ischial stage 3 PU. Interventions included: encourage and assist as needed to turn and reposition; use pillows/positioning devices as needed; limit prolonged elevation of head of bed if appropriate; check for incontinence and provide incontinence care; and (3/2/18) intervention added for low air loss mattress to bed.	F 686		

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F 686	Continued From page 16 2/28/18 Physician order - maintain resident on air mattress while in bed. Perimeter cover at all times. 2/28/18 CNA documentation stated that the low air loss mattress is now on the bed. (no evidence that it was applied prior to 2/28/18). The facility identified a new skin impairment on R3's left ischium on 2/13/18 that progressed to a Stage 3 PU on 2/18/17; a low air loss mattress for pressure relief was not applied to her bed until 2/28/18. No intervention to off-load site initiated. The facility failed to show evidence that R3 was educated on risk of prolonged periods of time in wheel chair without pressure relief. The facility relied solely on the inaccurate Braden scale scores to determine whether to implement a pressure relieving mattress. The facility failed to take into account the resident's physical conditions which included incontinence and quadriplegia when planning additional interventions. During an interview on 4/16/18 at approximately 3:00 PM, the above findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON). E3 and E2 confirmed that an incident and investigation should have been started when R3's wound was found on 2/13/18. E3 confirmed that a low air loss mattress was not applied to the bed until 10 days after the stage 3 PU was identified. E1 stated that R3 caused this skin issue herself by refusing to turn (although facility documentation revealed that R3 refused turning only 8.9% of the time) and remaining in her wheelchair for extended periods of time.	F 686		

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F 686	Continued From page 17 The facility failed to provide the necessary care and services for R3 to prevent the development of an avoidable pressure ulcer. 2. Review of R4's clinical records revealed the following: On April 13, 2016, NPUAP updated the stages of pressure injury (ulcer) with the elimination of the term: Suspected Deep Tissue Injury (SDTI). (http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury.) The facility's policy and procedure titled Skin and Wound Management stated, upon discovery of a resident with impaired skin, the licensed nurse will notify the Wound Nurse RN or designee. The Wound Nurse RN or designee will assess the wound and determine if it is a pressure ulcer and then initiate the appropriate treatment. Review of R4's clinical records revealed the following: 2/26/18 - Readmitted to the facility from the hospital. 2/26/18 - Admission nursing assessment documented a SDTI PU of the left heel measuring 3.0 cm X 2.0 cm X 0 cm. Record review revealed that the facility's Electronic Medical Record System (EMRS) continued to include the obsolete stage of SDTI for PU. Additionally, the assessment of the PU lacked documentation of the additional physical	F 686		

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F 686	Continued From page 18 characteristics including tissue type, color, periwound condition, wound edges, sinus tract, undermining, tunneling, exudate, and odor. 4/16/18 at approximately 11:00 AM - An interview with the facility's Wound Care Nurse (E6), in the presence of E2 (DON) was conducted. E6 verbalized at the time of admission, R4's left heel wound had eschar and E6 staged it as an evolving DTI. Upon Wound Rounds with the Consultant Wound Care Nurse Practitioner, E13, it was determined that it was unstageable. E6 reiterated, from the time of admission on 2/26/18 to when E13 assessed the PU, there was no change. 4/17/18 at approximately 8:30 AM - An interview with E2 was conducted. E2 confirmed the presence of SDTI in the facility's EMRS as a current stage for PU. Additionally, E2 confirmed the admission PU assessment failed to include the above physical characteristics. At the conclusion of the interview, the surveyor requested the facility's policy and procedure, related to the staging of PU as well as expectation for assessing a PU, including documentation of the of physical characteristics of the PU. Following this interview, no additional information was provided to the surveyor. The facility failed to ensure R4's left heel PU was accurately staged and physical characteristics of the PU thoroughly and completely documented. Findings reviewed on 4/17/18 at approximately 4:30 PM with E1 (NHA), E2, E3 (ADON), and E4 (LPN) during the Exit Conference.	F 686		
F 694	Parenteral/IV Fluids	F 694		6/14/18

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F 694 SS=D	Continued From page 19 CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview, and review of facility's policies and procedures, it was determined that the facility failed to ensure that care and services were provided for two (R1 and R8) out of eight (8) residents sampled, who received parenteral fluids consistent with professional standards of practice and in accordance with physician orders. Findings include: The facility's pharmacy policy and procedure (P & P) titled Central Vascular Access Device: Site Care and Dressing Change, revised December 2014 states, "...GUIDANCE: 1. Dressing changes using transparent dressings are performed. A. 24 hours post [after] insertion. B. At least weekly ... 7. Length of external catheter is obtained upon admission ..". "PROCEDURE: 12. Measure/note length of external catheter." 1. Review of R1's clinical record review revealed the following:	F 694	A. R1 was discharged on 3/6/18. R8 was discharged on 4/17/18. No corrective action could be taken for R1 or R8. B. A facility wide audit will be conducted to identify all residents with central venous access devices (CVAD). Any resident(s) identified with a CVAD will be reviewed and corrected immediately to ensure compliance with the CVAD Policy and Procedure. C. Licensed staff will be re-educated on the CVAD Policy and Procedure by the staff development nurse or designee. A central venous device training and competency will be provided to licensed staff and re-evaluated as indicated. D. A CVAD audit will be conducted to ensure CVAD Policy and Procedures are followed daily for 3 months for any resident with this type of device and until 100% compliance is achieved. Audits will be conducted by the UM or designee. Results of this audit will be pulled through the QA Committee x 3 months.	

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F 694	Continued From page 20 5/15/17 - R1 was admitted to the facility from the hospital. 9/1/18 - Monthly orders included : - IV PICC line, antibiotic to be administered daily for bone infection (initial order date of 5/16/17). - IV PICC line, antibiotic to be administered three times a day for blood infection (initial order date of 5/15/17). - IV PICC line, flush with 10 ml of Normal Saline Solution (NSS) before and after administration of medication (initial order date of 5/15/17) . - IV PICC line, flush with 10 ml NSS every shift (initial order date of 5/15/17). - Blood test to be completed every Wednesday and results faxed to infectious disease physician, E16 (initial order date of 5/15/17)- 9/6/18 and timed 2:24 PM - Progress Note documented while E12 (LPN) was removing the dressing from the PICC insertion site, E12 had observed that the external catheter length increased to 3 cm and the previous weekly measurement was 1 cm. E12 notified E14 (MD) and orders obtained for stat chest x-ray to confirm placement of the catheter and to hold the IV antibiotics. Although the above P & P stated to measure/note length of external catheter, the facility failed to have a written process, on what actions should be taken. Record review lacked evidence that the facility identified the need to hold the order to flush the PICC line every shift. 9/6/17 and timed 4:22 PM - Chest x-ray result documented "...The 10th of the PICC line is at the upper 3rd superior vena cava..."	F 694		

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F 694	Continued From page 21 9/6/17 and timed 11:00 PM - Progress Note, by E7 (RN) documented that results of the chest x-ray were reported to the primary care provider. 9/6/17 - Medication Administration Record documented that the PICC line was flushed with 10 ml of normal saline solution during night shift on 9/6/17 despite the fact there was a question whether the PICC line was in the correct location. 9/7/17 and timed 7:50 AM - Progress Note by E15 [RN], the night shift nurse documented that the chest x-ray came back "PICC line is at the upper 3rd superior vena cava and the weekly lab could not be drawn." Although the weekly laboratory test could not be obtained, the facility failed to notify the attending physician (E14). 9/7/17 - MAR documented that the PICC line was flushed with 10 ml of normal saline solution on day shift despite the fact there was a question whether the PICC line was dislodged. 9/7/17 and timed 10:49 PM - Progress Note by E7 documented "Scheduled lab draw on 9/8/17." 9/8/17 and timed 8:46 AM - Order to discontinue PICC. 9/8/18 and timed 12:35 PM - Progress Note by E6 (WNRN), documented that the PICC line was removed by E6 and the PICC line measured 39 cm and this length was the same when the PICC line was inserted. The tip of the PICC line was intact and direct pressure held for 10 minutes, with no oozing or hematoma present at the site of	F 694		

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F 694	Continued From page 22 the PICC insertion. Dressing was placed over the site. 4/12/18 at approximately 9:25 AM - An interview with E2 (DON) confirmed that the facility failed to obtain an order to hold the NSS flush when there was a possibility that the PICC line was dislodged. 4/12/18 at approximately 3:35 PM - An interview with E6 revealed, prior to E6 removing R1's PICC line on 9/8/17, she had experience in other settings. E6 verbalized since her employment at the facility in 2016, the skill competency to remove PICC line has not been completed and she was unaware of the need to have this completed prior to actual removal of a PICC line. E6 related that she has had extensive nursing experience and had performed this procedure at other healthcare settings. 4/16/18 at approximately 2:45 PM - An interview with E1 (NHA) confirmed that the facility failed to hold the NSS flush during the shifts noted above. However, E1 verbalized that since E14 was the physician overseeing R1's care while in the facility, consultation with E16 when the antibiotic had to be held beginning 9/6/18 was not needed. Additionally, E1 verbalized, it was his opinion when the weekly blood could not be drawn on 9/7/17, there was not a need to notify the infectious disease physician, R16. 4/17/18 at approximately 9:26 AM - An interview with E17 (RN UM) revealed she recalled that the PICC line was dislodged and the contracted infusion services vendor was contacted. Surveyor verbalized to E17 that there was no evidence of the contact with the contracted	F 694		

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F 694	Continued From page 23 vendor. E17 verbalized she does not recall the specifics but does recall shortly after the PICC was removed, the plan was to have a new PICC line placed on 9/13/17. 4/17/18 at approximately 10:23 AM - An interview with the attending physician, E14, revealed that he could not recall if he was contacted on 9/6/17, however, if there was a question about the PICC line being dislodged, the order for the NSS flush per shift should have been held as well. In addition, E14 verbalized that he did not recall receiving the results of the chest x-ray. Surveyor proceeded to read the conclusion of the report, as noted above. E14 verbalized that it would be his opinion that the PICC was likely not in the correct location. Surveyor inquired if he was made aware of this result, whether he would have ordered the PICC to be removed and E14 verbalized that he may not but would have requested a consult by the infusion services vendor. E14 asked the surveyor, was there any order on 9/6/17, when the Progress Note timed 11:00 PM documented that the primary care provider was notified. Surveyor reported there was no subsequent order for 9/6/17. 4/18/18 - An interview with E18, staff of the contracted infusion services vendor, revealed that for removal of a PICC line, the expected standard would be that the facility have a process to evaluate the competency of the nurses prior to the procedure as well as periodic re-evaluation of competency. 4/18/18 - Surveyor received a copy of the pharmacy's policy and procedure titled Central Venous Access Devices: Removal with the most recent revision date of 12/2014 from E2 [DON].	F 694		

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F 694	Continued From page 24 Subsequent to receiving this P & P, the surveyor inquired if skill competency was completed prior to the staff performing this task? E2 replied that she was uncertain whether this was an expectation when R1's PICC was removed on 9/8/17 since E2's employment began in February 2018. When asked is there a competency expectation currently and E2 responded, "I will need to look into it." No response was received subsequent to this inquiry. The facility failed to have evidence of a development and implementation of resident care policies, based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuance of the IV as well as prevention of infection at the site to the extent possible. The procedures must include the care and use of all equipment, such as pumps, tubing, syringes, fluids, etc. This failure resulted in the flushing of R1's PICC line when there was questionable dislodgement of the PICC line. In addition, the facility failed to develop a set criteria to evaluate the competency of nurses for the overall care of the PICC line including removal of the PICC line. 2. Review of R8's clinical record revealed the following: 2/22/18 - R8 was admitted to the facility following hip surgery. 3/2/18 - Order to insert a PICC line. 3/2/18 - PICC line inserted by a staff member of a contracted vendor. Record review lacked evidence of an initial	F 694		

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F 694	Continued From page 25 measurement of the external catheter when the PICC was inserted on 3/2/18. 3/3/18 - Orders included to change PICC line dressing weekly every Wednesday and to Monitor PICC line site for signs and symptoms of infection every shift. Record review lacked evidence of a 24 hours post [after] PICC insertion dressing change. 3/5/18 - A care plan for potential complication at IV insertion site in right upper arm was developed and implemented. Intervention included dressing change by physician order and as needed if soiled or wet. 3/14/18 through 4/11/18 - Treatment Administration Record documented PICC dressing change was completed every week on Wednesday as ordered. Record review lacked evidence of the measurement of the external catheter during the weekly dressing change. 4/12/18 at approximately 9:18 AM - An interview with E15 (RN UM) confirmed the facility failed to have evidence of an initial measurement of the external catheter when the PICC was placed on 3/2/18, failed to have evidence of a dressing change on 3/3/18, and failed to have evidence of a weekly measurement of the external catheter for five consecutive weeks. 4/12/18 at approximately 9:30 AM - An interview with E2 (DON) confirmed the facility failed to have evidence of a dressing change 24 hours after the PICC insertion on 3/2/18.	F 694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 694	Continued From page 26 The facility failed to ensure that R8, who received intravenous antibiotic via a PICC line, received care and services consistent with professional standards of practice and in accordance with physician orders. On 4/17/18 at approximately 4:30 PM, findings were reviewed with E1 [NHA], E2, E3 (ADON), and E4 (LPN) during the Exit Conference.	F 694		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure quality of radiology services for one (R1) out of eight sampled residents. Findings include: Cross refer F694, example 1. Review of R1's clinical record review revealed the	F 776	A. R1 was discharged on 3/6/18 therefore no corrective action can be taken. B. All residents with radiology services performed in the last 30 days, reports will be reviewed by the Medical Director and re-read by the radiology vendor for	6/14/18

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F 776	Continued From page 27 following: 5/15/17 - R1 was admitted to the facility from the hospital. 9/6/17 - Order for stat chest x-ray to confirm placement of PICC. 9/6/17 and timed 4:22 PM - Chest x-ray result documented "...The 10th of the PICC line is at the upper 3rd superior vena cava..." 9/6/17 and timed 11:00 PM - Progress Note, by E7 (RN) documented that results reported to primary care provider. 4/17/18 at approximately 8:18 AM - Telephone interview with a staff member at contracted radiology vendor, E18, was conducted. E18 verbalized that the conclusion documented of "The 10th.." was an error and the report will be corrected. The facility failed to ensure the quality of the radiology services, specifically the conclusion of the report. Above findings discussed with E1 (NHA) on 4/17/18 at approximately 9:45 AM.	F 776	accuracy if indicated by the Medical Director. Any discrepancies identified in these reports will be corrected and reviewed by the ordering physician for follow up if indicated. C. Licensed staff will be re-educated by the staff development nurse or designee on the Radiology Policy and Procedure that clarifies the protocol to be followed in the event of an unclear conclusion within an ordered radiology report. D. Daily audits will be performed by the DON or designee on all radiology results with a specific focus on the conclusion of the report x 3 months and until 100% compliance is achieved. The vendor will re-read 10% of all radiology reports weekly X 3 months and report findings to the facility. The results of both facility and vendor audits will be pulled through the QA Committee meeting monthly x 3.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center **DATE SURVEY COMPLETED: April 17, 2018**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from April 10, 2018 through April 17, 2018. The facility census on the first day was 151. The survey sample included 8 residents.	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements	
3310 **3310.1.0** **3310.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed April 17, 2018: F637, F686, F694, and F776.	Cross refer to the CMS 2567-L survey completed April 17, 2018: F637, F686, F694 and F776.	6/14/18

Provider's Signature N. Pugh Title NHA Date 5/11/18